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UNITED STATES CIVIL SERVICE COMMISSION

FEDERAL PERSONNEL MANUAL SYSTE

LETTER

Washington, D. C. 20415
November 22, 1965

FPM LETTER NO. 890-11

SUBJECT: Federal Employees Health Benefits Program: Effect of Medicare on Federal Employees.

Heads of Departments and Independent Establishments:

I. BASIC MEDICARE PROVISIONS

The Social Security Amendments of 1965 (Public Law 89-97), establish two kinds of health insurance, popularly known as Medicare, for persons age 65 or over:

HOSPITAL INSURANCE, which provides payments for inpatient hospital services, posthospital extended care services, posthospital home health services, and outpatient hospital diagnostic services; and

MEDICAL INSURANCE, which provides payments for physicians' services and other medical items and services not covered by the hospital insurance.

The exact benefits of the hospital and medical insurance are not detailed here because they are fairly common knowledge and an official, authoritative description of them is available at any social security office.

A. Hospital Insurance.

This becomes effective July 1, 1966, except that benefits for post-hospital extended care services become effective January 1, 1967.

INQUIRIES: Bureau of Retirement and Insurance, 343-6384 (Code 183)

CSC CODE: 890, Federal Employees Health Benefits

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There is no direct monthly or other periodic premium cost to the covered individual. It automatically covers all individuals, including Federal employees, who are (1) age 65 or over and (2) entitled to monthly social security or railroad retirement benefits.

Under a transitional provision in the Medicare law, individuals who are age 65 or over (or who will be 65 before January 1, 1968) and are not entitled to monthly social security or railroad retirement benefits, may also be eligible for hospital insurance. These individuals must apply to the Social Security Administration for this coverage.*

However, excluded from the transitional provision is any individual who, at the time he would otherwise become entitled under the provision, is covered by a plan under the Federal Employees Health Benefits Act of 1959, as well as any individual who could have been so covered if he or some other person had availed himself of opportunities to enroll under that act and to continue such enrollment. This excludes from Medicare's hospital insurance under the transitional provision any Federal employee (and his spouse) who is or could have been enrolled in a plan under the Federal Employees Health Benefits Program.**

Please note that the exclusion applies only to hospital insurance under the transitional provision. Any Federal employee who is entitled to social security or railroad retirement benefits still automatically acquires the hospital insurance, even though he is enrolled in a plan under the Federal Employees Health Benefits Program.

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* Also eligible under the transitional provision are individuals who reach 65 after January 1, 1968, and have or acquire a specified minimum number of quarters of social security or railroad retirement coverage.

** Not excluded from hospital insurance coverage under the transitional provision are (1) annuitants and their spouses, if the annuitant retired before February 16, 1965, and was not enrolled under the Federal Employees Health Benefits Program on that date, and (2) former Federal employees and their spouses who were not eligible to continue their enrollments under the Program upon separation from the Federal service. Also not excluded are annuitants and their spouses who are enrolled under the Retired Federal Employees Health Benefits Act of 1960 which applies only to annuitants who retired before July 1, 1960.

B. Medical Insurance.

This coverage is not automatic. It is entirely voluntary and is available only on application to the Social Security Administration.

Generally, anyone age 65 or over, including a Federal employee and annuitant, is eligible to enroll for this coverage.

It also becomes effective July 1, 1966, for individuals who apply on or before March 31, 1966.

The premium for the medical insurance is $3 per month per individual, which is matched by the Government from general revenue funds. This premium will be withheld from the monthly benefit payments of those who receive social security, railroad retirement, or civil service retirement annuities.

Individuals who do not enroll at their first opportunity will have to wait two years for the next opportunity and pay a higher premium.

C. Applying for Medicare.

Employees age 65 or over who are entitled to social security or railroad retirement monthly benefits need not go to the Social Security office to apply for either part of Medicare. The hospital insurance is automatic and applications for the medical insurance have been mailed to them by the Social Security Administration.

Employees who are interested in, and can qualify for, Medicare's hospital or medical insurance but who are not receiving social security or railroad retirement monthly benefits because they have worked under social security but never applied for benefits or because they never worked under social security, should visit their social security office to establish their eligibility.

II. ADJUSTMENT OF FEDERAL EMPLOYEE PLANS

Many age-65-or-over employees and their spouses will automatically qualify for Medicare's hospital insurance because they are entitled to social security or railroad retirement benefits. Some of these will also elect to enroll for the medical insurance. Other 65-and-over employees and their spouses who cannot qualify for the hospital insurance will, nevertheless, enroll for the medical insurance. And any one of the above-mentioned individuals may also continue his enrollment in a plan under the Federal Employees Health Benefits Program.

In general, Federal employee health benefits plans afford protection against the same expenses as Medicare. Many of the plans provide benefits for expenses beyond and in addition to those which Medicare covers. For example,

many plans cover hospitalization for more than the 90 days covered by Medicare, and without the deductible and coinsurance required by Medicare. Another example: many plans cover expenses for prescription medicines and private nurses, neither of which are covered by Medicare. (Conversely, Medicare's hospital insurance, under certain conditions, covers post-hospital extended care, i.e., nursing homes, which are not usually covered by the Federal employee plans.)

To prevent an individual's receiving from Medicare and his Federal employee plan benefits which amount to more than his medical expenses, all Federal employee plans will apply an antiduplication provision. This means that, when Medicare becomes effective, all plans will adjust their benefits so that in effect they supplement, rather than duplicate, the benefits provided by Medicare. As a general rule, if an individual is covered by Medicare's hospital and/or medical insurance and by a Federal employee plan, the plan will pay (or provide) its benefits in full or in a reduced amount which, when added to the benefits payable under Medicare, will not exceed 100% of allowable expenses.

Even though an employee, or his spouse, or both are covered by Medicare's hospital and/or medical insurance and the benefits under his plan may therefore be reduced, there is no reduction in subscription charge for his Federal employee plan. There are at least two reasons for not reducing premiums: (1) the Federal Employees Health Benefits law permits only two types of subscription charge categories-- self-only and self-and-family and (2) as a class, persons over 65 use between two and three times as much medical care as younger people, and the true cost of the supplementary coverage under a Federal employee plan for age-65-and-over individuals would be roughly about the same as they now pay (older people are presently subsidized by the younger).

New health benefits plan brochures and the pamphlet (BRI 41-117) detailing changes in plans for next year will contain notice of the antiduplication provision. However, installations may wish to publicize this, as well as other information in this letter, to their 65-and-over employees in whatever way is deemed best.

III. CHOICES EMPLOYEES CAN MAKE

As is evident from the foregoing, age 65-and-over employees are confronted by a multiplicity of options which employing offices may be asked to explain.

Health insurance is, of course, extremely personal. What is adequate for one individual may be inadequate for another. It depends on many things, including for example, family composition, the state of the family's health,

the financial ability to meet medical expenses out-of-pocket or to pay more insurance premiums. Therefore, the employing office may explain the available options and answer an employee's questions but it should not undertake to decide which option is best for the particular employee. Each employee must decide for himself which option is best for him.

There are several pieces of general advice that may be given to all employees:

- Do not now, because of Medicare, cancel the Federal employee plan you now have. Federal employee plan cancellations or changes to self-only enrollments because of Medicare should be timed to coincide with the date Medicare becomes effective -- July 1, 1966, or later when the employee or spouse attains age 65.

- If you cancel your Federal employee plan and later change your mind, you may not, under the health benefits law and regulations, be able to reenroll (or to continue enrollment after retirement).

- Compare the benefits of your Federal employee plan as explained in the brochure with those of Medicare.

- Medicare's hospital and medical insurance, together, offer good protection at a very reasonable premium. However, coverage under the hospital insurance alone or the medical insurance alone would have to be considered inadequate protection.

- The premiums and benefits of Federal employee plans and Medicare are subject to change in the future. No one now knows what these changes will be.

With the above basic considerations in mind, here are the most usual situations and options employees will be confronted with and the advice which they may be given to consider in making their decisions.

- If the employee is not enrolled in, or covered as a family member by, a Federal employee plan, and is eligible for Medicare's hospital insurance, he should also enroll for the medical insurance to get maximum protection.

- If the age-65-or-over employee who is entitled to Medicare has a spouse under 65 (or children) who is not eligible for Medicare, he may wish to continue his family enrollment in his Federal employee plan to protect his spouse (or children).

- If the employee is under age 65 but his spouse is 65 or over and entitled to Medicare, he may wish to change his Federal employee plan family enrollment to a less expensive self-only enrollment unless, of course, there are children to protect, or he wants to supplement the spouse's Medicare coverage with his Federal employee plan.

- If an employee is not eligible for Medicare's hospital insurance, there is no clear advantage in enrolling for the medical insurance only. If he does enroll for the medical insurance only, it may not be wise to cancel his Federal employee plan.

- If an employee is eligible for Medicare's hospital insurance and is considering cancelling his Federal employee plan, he should also enroll for the medical insurance before cancelling to get maximum protection.

- If an employee is eligible for hospital insurance but his spouse is not because she is under age 65, he probably should enroll for medical insurance if he intends to drop his Federal employee plan when his spouse reaches 65 and qualifies for Medicare. (Individuals who do not enroll for the medical insurance at their first opportunity must wait two years for the next opportunity and must pay a higher premium.)

- Any employee who would qualify for Medicare's hospital insurance by applying for it should do so, regardless of whether he enrolls for the medical insurance and even though he is in a Federal employee plan.

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